Arizona Health Care Cost Containment System

May-June, 2002

ENCOUNTER KEYS

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DO NOT CORRECT ENCOUNTERS DURING BATCH PROCESSING

Recently, during encounter processing a contractor corrected a few pended encounters on-line. Working pended encounters during processing may cause significant problems. Please wait until processing has completed prior to correcting encounters on-line. Following encounter processing completion, contractors are notified via email. If you are uncertain when encounters may be corrected on-line, please contact your Technical Assistant.

MEDICARE BILLING REQUIREMENTS

Do not deny services as a result of Medicare billing requirements. Providers, due to Medicare billing reimbursement policy changes, may be submitting claims differently. **Do not deny services as a result of Medicare's changes.**

AHCCCS is updating reference tables to accommodate these billing changes. Note that AHCCCS claims or encounter processing and reimbursement methodology does not change. If you believe an encounter is pending due to Medicare's changes, please contact your Technical Assistant.

DILEMMAS

For the months of May and June the following error code conditions are not subject to sanction.

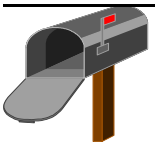
S385 – Service Units Exceed Maximum Allowed (pertains only to the 80000 procedure codes).

Z720 – Exact Duplicate Found (for dental encounters when multiple tooth surfaces are reported).

P015 - Service Provider Type Invalid For Uniform Billing Form

S841 - ASC Procedure Code Is Not Covered

S842 - ASC Procedure Code is Not Classified



AHCCCS ENCOUNTER

OPERATIONS UNIT

P.O. Box 25520

Phoenix, AZ 85002-5520

Mail Drop #8500

Fax: 602-417-4725

Internet:www.ahcccs.state.az.us/publications

For Technical Assistance contact:

Peggy Brown (602) 417-4662

Ester Hunt (602) 417-4140

Correction to Late Charges Reporting

In the March/April 2002 Encounter Keys issue, "Separate Encounters for Late Charges," it was incorrectly reported, "Late charge claims must be combined with the original inpatient claim and reported as a single encounter. If the original claim has already been encountered to AHCCCS, the late charge claim and original claim must be combined and submitted as a single replacement encounter."

Contractors may combine late charge encounters with the original inpatient encounter or report late charge encounters separately from the original inpatient encounter. If contractors choose to combine late charge encounters with original inpatient encounters, the late charge and original must be combined as one encounter. We apologize for any inconvenience caused by the publication error.

FIRST MODIFIER

Effective immediately, the error code S444 (Primary Modifier Required When Secondary Modifier Present) will pend encounters when a procedure has a second modifier but no modifier in the first position. If only one modifier is reported, please verify that the modifier is reported in the first position and not the second.

INVALID MODIFIER

If encounters pend for S445 (Procedure Modifier Invalid for Procedure on Date of Service), please verify that the modifier is valid. Valid modifiers may be found on the PMMIS reference screen RF 114 (Procedure Modifiers). In addition, please confirm that the procedure and modifier combination are valid. Valid combinations may be found on the PMMIS reference screen, RF122 (Valid Procedure Modifiers), and in the monthly reference Refer02 file available on the FTP server.

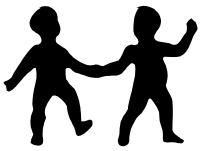
MULTIPLE SURGERIES

When the provider performs multiple procedures during the same operative session, the primary procedure should be reported first followed by the additional procedures. Additional procedures should be reported using the modifier 51 (multiple procedures).

For example, a provider operates on 5 separate tendons during the same surgical session. The provider should report 25290 (Tenotomy, open, flexor or extensor tendon, forearm and/or wrist, single, each tendon) as the primary procedure with one unit, and 25290-51 with 4 units as additional procedures. Payment therefore, should be at 100% for the first tendon and 50% at each additional.

ULTRASOUND ON TWINS

Should an ultrasound on twins be reported as 76805 (Echography, pregnant uterus, B-Scan and/or real time with image documentation; complete [complete fetal and maternal evaluation]) with 2 units or as 76810 (complete [complete fetal and maternal] multiple gestation, after the first trimester) with 1 unit?



The 76805 ultrasound is for one complete maternal and fetal evaluation (1 unit). This ultrasound procedure would be used for multiple gestation during the first trimester. The 76810 ultrasound is complete maternal and fetal evaluation for multiple gestations and may be used only after the first trimester (1 unit).

DENTAL EDITS

Dental services (D HCPCS Level II codes) for dates of service on and after October 1, 2000 **must be reported on the dental encounter layout**. Dental services for dates of service on and after October 1, 2000 submitted on a HCFA 1500 encounter layout will pend for services reported on incorrect format.

AGE, GENDER & SERVICE UNIT GUIDE-LINES

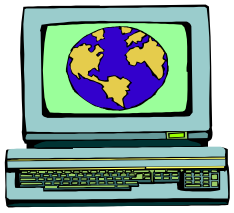
AHCCCS age, gender, and service unit limitations are guidelines. Appropriate services on claims that exceed these limitations should not be denied solely on the basis of AHCCCS age, gender and service limits. Encounters pending for exceeding age, gender, or service unit limitations, should be reviewed for data input errors. In addition, coding descriptions for codes reported should be reviewed for correct billing. If the claim is identical to the encounter, and contractor medical review approved or reviewed the claim prior to payment, please forward documentation pertaining to the claim to your encounter Technical Assistant.

EDIT RESOLUTION

A new set of Edit Resolutions were distributed at the Quarterly Health Plan Meeting , held on April 30th. A copy of these resolutions can be found on the AHCCCS web site, www.ahcccs.state.az.us/Publications/Edit Resolutions

ADHS MATRIX

Arizona Department Health Services Behavior Health Services (BHS) has issued their updated BH Services Guide. It is on the infonet at: http://infonet/regulations/behavioralhealth/index.asp or website at: www.ahcccs.state.az.us/publications/behavioralhealth/behavioralhealth_index.asp .



NON-COVERED SERVICES

Institutional claims should not be denied as a result of a non-covered service (revenue code). Charges for non-covered services should be excluded from payment and the remaining payable services processed for payment. To submit these encounters to AHCCCS, the non-covered service (revenue code) total charges are reported in both the billed charges field and non-covered charges field.

PROVIDER LOCATOR CODE

Encounters must be reported with servicing provider identification number. Encounters pending for P200 (Service provider locator code not on file) must be withdrawn and resubmitted with the provider identification number who performed the service, e.g., physician (provider type 08), hospital (provider type 02), or nurse practitioner (provider type 19). Group payment identification numbers (provider type 01) must not be used as the service provider identification number. If group payment numbers are used, encounters will pend for P200 error code.

MEDICARE DEDUCTIBLE & COINSURANCE

For institutional encounters, Medicare deductible and coinsurance information must be reported in the value code and amount fields. Value code A1 designates Medicare Part A deductible and A2 indicates Medicare Part A coinsurance amounts. Value code B1 specifies Medicare Part B deductible and B2 identifies Medicare Part B coinsurance amounts. Additional guidance on reporting Medicare deductible and coinsurance amounts on institutional claims/encounters may be found in the National Uniform Billing Data Element Specifications as developed by the National Uniform billing Committee. To obtain the latest specifications update, please contact the American Hospital Association, One North Franklin, Chicago, Illinois 60606 or www.nubc.org.

PROVIDER TYPE 10, 22 & 43

The following codes have been added to the Provider Types listed below:

Code	Description	Provider Type
27610	Arthrotomy, Ankle, Including Exploration, Drainage	10 - Podiatrist
90658	Influenza Virus Vaccine, Split Virus, 3 years & above	22 – Nursing Home
90659	Influenza Virus Vaccine, Whole Virus, Intramuscular	22 – Nursing Home
Q1001-Q1002	New Technology IOL	43 – ASC

PROCEDURE CODE UPDATES

Age Limit has been lowered to 000 on the following codes:

71.4 Operations on Clitoris
21079 Impression and Custom preparation; interim obturator prosthesis
21080 Impression and Custom preparation; definitive obturator prosthesis
L1500 Thoracic-Hip-Knee-Ankle or Thosis (Thkao), Mobility Frame (Newington, Parapodium types)
L2200 Addition to lower extremity, limited ankle motion, each joint
L2210 Addition to lower extremity, Dorsiflexion Assist (Plantar Flexion Resist)
L2220 Addition to lower extremity, Dorsiflexion and Plantar Flexion assist/resist
L2230 Addition to lower extremity, split flat caliper stirrups and plate attachment
L2240 Addition to lower extremity, round caliper and plate attachment
L2250 Addition to lower extremity, foot plate, molded to patient model
L2260 Addition to lower extremity, reinforced solid stirrup (Scott-Craig type)
L2265 Addition to lower extremity, long tongue stirrup
L2270 Addition to lower extremity, varus/valgus correction (“T”) strap
L2275 Addition to lower extremity, varus/valgus correction, plastic modification
L2280 Addition to lower extremity, molded inner boot
L2300 Addition to lower extremity, abduction bar (bilateral hip involvement)
L2310 Addition to lower extremity, abduction bar-straight
L2320 Addition to lower extremity, non-molded lacer
L2330 Addition to lower extremity, lacer molded to patient model
L2335 Addition to lower extremity, anterior swing band
L2340 Addition to lower extremity, pre-tibial shell, molded to patient model
L2350 Addition to lower extremity, prosthetic type, (BK) socket
L2360 Addition to lower extremity, extended steel shank
L2370 Addition to lower extremity, patten bottom
L2375 Addition to lower extremity, torsion control, ankle joint & half solid stirrup
L2380 Addition to lower extremity, torsion control, straight knee joint
L2385 Addition to lower extremity, straight knee joint, heavy duty, each joint
L2390 Addition to lower extremity, offset knee joint, each joint
L2395 Addition to lower extremity, offset knee joint, heavy duty, each joint
L2397 Addition to lower extremity orthosis, suspension sleeve
L2750 Addition to lower extremity orthosis; plating chrome or nickel, per bar
L2755 Addition to lower extremity orthosis, high strength, lightweight
L2760 Addition to lower extremity orthosis, extension, per bar
L2768 Orthotic side bar disconnect device, per bar
L2770 Addition to lower extremity orthosis, any material-per bar or joint
L2780 Addition to lower extremity orthosis, non-corrosive finish, per bar
L2785 Addition to lower extremity orthosis, drop lock retainer, each
L2795 Addition to lower extremity orthosis, knee control, full kneecap
L2800 Addition to lower extremity orthosis, knee control, knee cap, medial or lateral pull
L2810 Addition to lower extremity orthosis, knee control, condylar pad
L2820 Addition to lower extremity orthosis;soft interface for molded plastic, below knee
L2830 Addition to lower extremity orthosis, soft interface for molded plastic, above knee
L2840 Addition to lower extremity orthosis, tibial length sovk, fracture or equal, each
L2850 Addition to lower extremity orthosis; femoral length sock, fracture or equal, each
L2860 Addition to lower extremity joint, knee or ankle, concentric adjustable torsion
L2999 Lower extremity orthosis, not otherwise specified